WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

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FILE COPY

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
PATRICIA PEETERS, R.N., RESPONDENT.	:	FINAL DECISION AND ORDER

ORDER 0001416

The parties to this action for the purposes of Wis. Stats. sec. 227.16 are:

Patricia Peeters, R.N.
718 Oak Street
De Pere, Wisconsin 54115

Board of Nursing
P. O. Box 8936
Madison, Wisconsin 53708-8936

Department of Regulation & Licensing
Division of Enforcement
P. O. Box 8936
Madison, Wisconsin 53708-8936

A party aggrieved by this decision may petition the Board for rehearing within twenty (20) days after service of this decision pursuant to Wis. Stats. sec. 227.12. The petition in this instance would be captioned with Patricia Peeters, R.N. as the respondent.

A party aggrieved by this decision who is a resident of this state may also petition for judicial review by filing the petition in the office of the clerk of the circuit court for the county where the party aggrieved resides within thirty (30) days after service of this decision. A party aggrieved by this decision who is not a resident of this state must file the petition for judicial review in the office of the clerk of circuit court for Dane County. A party aggrieved must also serve the board and other parties with a copy of the petition for judicial review within thirty (30) days after service of this decision pursuant to Wis. Stats. sec. 227.16. The party to be named as respondent in the petition is the State of Wisconsin Board of Nursing.

The parties in this matter agree to the terms and conditions of the attached stipulation as the final disposition of this matter, subject to the approval of the Board. The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached stipulation and, for the purposes of this action only, makes the following:

FINDINGS OF FACT

1. Patricia Peeters is duly licensed in the State of Wisconsin as a registered nurse (license number 24888); this license was issued on November 16, 1950.

2. At all times relevant herein, Ms. Peeters was acting as the Director of Nurses at Ridge View Nursing Center in De Pere, Wisconsin.

3. On May 5, 1983, Ridge View Nursing Center was served with a notice of violation [Wis. Adm. Code sec. 132.43(2): Resident abuse] by the State of Wisconsin Department of Health & Social Services, Bureau of Quality Compliance. A copy of the notice of violation is attached to this stipulation and incorporated by reference herein.

4. Ms. Peeters retired from nursing in October, 1983. She has not worked as a nurse since that time.

CONCLUSIONS OF LAW

By the conduct described above, Ms. Peeters is subject to disciplinary action against her license pursuant to Wis. Stats. sec. 441.07(1)(d) and Wis. Adm. Code sec. N 11.04(3).

Therefore, it is hereby ORDERED:

The license of Ms. Peeters to practice as a registered nurse in the State of Wisconsin is SUSPENDED for at least six (6) months and until such time as Ms. Peeters demonstrates successful completion of three course credits acceptable to the Board in supervisory nursing.

This order shall become effective ten (10) days following the date of its signing.

BOARD OF NURSING

By: John Bartkowski (PRP) November 27, 1985
A Member of the Board Date

SMG:kcb
2638

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE LICENSE OF PATRICIA PEETERS, R.N., RESPONDENT.	STIPULATION

It is hereby stipulated between Patricia Peeters, R.N. personally on her own behalf and Steven M. Gloe, attorney for the Department of Regulation & Licensing, Division of Enforcement, as follows that:

1. This stipulation is entered into as a result of a pending investigation of Ms. Peeters' licensure by the Division of Enforcement (case file number 83 Nurse 44). Ms. Peeters consents to the resolution of this investigation by stipulation and without the issuance of a formal complaint.

2. Ms. Peeters understands that by the signing of the stipulation she voluntarily and knowingly waives her rights, including: the right to a hearing on the allegations against her, at which time the state has the burden of proving those allegations by clear, satisfactory, and convincing evidence; the right to confront and cross-examine the witnesses against her; the right to call witnesses on their behalf and to compel their attendance by subpoena; the right to testify yourself; the right to file objections to any proposed decision and to present briefs or oral arguments to the officials who are to render the final decision; the right to petition for rehearing; and all other applicable rights afforded to Ms. Peeters under the United States Constitution, the Wisconsin Constitution, the Wisconsin Statutes and the Wisconsin Administrative Code.

3. For purposes of resolution of this licensure action only, Ms. Gunness agrees to the adoption of the attached Final Decision and Order by the Board of Nursing.

4. If the terms of this stipulation are not acceptable to the Board, the parties shall not be bound by the contents of the stipulation, and the matter shall be returned to the Division of Enforcement for further proceedings.

5. If the Board accepts the terms of the stipulation, the parties to this stipulation consent to the entry of the attached Final Decision and Order without further notice, pleading, appearance or consent of the parties.

6. Attached to this stipulation is the current licensure card of Ms. Peeters. If the Board accepts the stipulation, her license shall be reissued in accordance with the terms of the attached Final Decision and Order. If the Board does not accept this stipulation, the license of Ms. Peeters shall be returned to her with the notice of the Board's decision not to accept the stipulation.

7. The Division of Enforcement joins Ms. Peeters in recommending the Board of Nursing adopt this stipulation and issue the attached Final Decision and Order.

May 15, 1985
Date

Patricia Peeters R.N.
Patricia Peeters, R.N.

May 17, 1985
Date

Steven M. Gloe
Steven M. Gloe, Attorney
Division of Enforcement

SMG:lmp
2239

DOH-2010 11/81

NOTICE OF VIOLATION OR DEFICIENCY (S)

This is a LEGAL DOCUMENT. Please read the back of this page.

A 253250

NOTICE OF CLASS A VIOLATION TO:

STATE OF WISCONSIN

No. 4 of 6 NOV's

Ridge View Nursing Center
Licensee

License Number 2338

Ridge View Nursing Center
Name of Facility and Provider Number

Route 1, Box 100 N52 6143 07
Address

De Pere, WI 54115
City State Zip

This Notice served on:
Ronald J. Desotell, NHA
(Chap. 50 Designee)

by Shirley Warpinski RN Surveyor's Signature & Title

☐ Certified Mail
☒ In Person

5-5-83
Date Served

10/5/82 Survey Date (X3)
465 Surveyor #
Interim-Complaint/Good Faith Survey Type
☐ Wing or ☐ Bldg. (XYZ2)
Date of Receipt D.O.: 5-19-83

State	Federal	Standard	Condition	HSS 132 Provision	CFR
☒ Violation	☒ Deficiency	☐ Not Met	☐ Not Met	HSS 132.43 (2)	

Page Question Numbers

Federal Tags (XYZ4)
(F73) 3HW T207

A. Date of Discovery: Multiple dates of investigation between 10/5/82 and 4/5/83
B. Date(s) of Violation: Approximately from the fall of 1979 at continued intervals
C. Nature of Violation: until 8/22/82.

The Director Nursing assigned a male employee, D.G., to duties not consistent with his level of education and experience to the detriment of residents in his care. D.G. originally was employed as a laundry worker on a work placement program made by the Curative Workshop, Green Bay, under contract with the Division of Vocational Rehabilitation.

D.G. later was assigned nursing assistant duties that included giving partial sponge baths, dressing and changing elderly, confused, incontinent and infirm female residents.

The personnel record of D.G. includes evidence that on-the-job training was provided in the conduct of these duties, however, various incidents and

Continued -----

PLAN OF CORRECTION: If you do not send this plan to the Agent within 15 days the Department will impose a plan.

5-19-83
Date of Completion (X5)

Plan:
Please see attached Plan

Ronald J. Desotell
Signature of Licensee or Designee

N.H.A.
Title

5-19-83
Date (X6)

DEPARTMENTAL ACTION ON PLAN OF CORRECTION: ☐ Approved ☐ Amended ☐ Rejected

Imposed Plan of Correction
1. A responsible staff person shall be designated by the Administrator to receive resident abuse complaints and any complaints alleging violations of resident's rights. The designee shall immediately report the allegation to the Administrator in writing. within two weeks of receipt of the complaint, A written report of the investigation shall be filed. The report shall include a summary of the investigation process, results or conclusions and action taken.

Continued ---

Signature of Department Representative Date

VERIFICATION VISIT I

☒ Corrected
☐ Waiver/Variance
☐ Acceptable Progress
☐ Not Corrected

HCFA Initial Date

Surveyor's Signature Date

5-9-83
New Completion Date or Date Corrected (YZ5)

Ronald J. Desotell
Provider's Signature Date (YZ3)

VERIFICATION VISIT II

☐ Corrected
☐ Waiver/Variance
☐ Acceptable Progress
☐ Not Corrected

Surveyor's Signature Date

New Completion Date or Date Corrected

Provider's Signature Date

observations reported by other employees were not acted upon appropriately by removing D.G. from direct patient care. D.G. continued working directly with female residents after he had been reported to the DON for sexually abusing Residents #58 and 142. D.G.'s contact with residents created a substantial threat to their physical and mental health, safety and welfare.

The following incidents took place and were reported: J.B., nursing assistant, reported that in the fall of 1979, she walked into the room of resident #58 and saw D.G., nursing assistant, sitting on the bed. Resident #58 was nude and was sitting on D.G.'s lap. D.G. had his arm around the resident's waist. J.B. notified the DON who reportedly spoke to Aide D.G. Aide D.G. reported to the DON that the resident had fallen against him. There was no evidence of reprimand or retraining. J.B. was told to report any further observed incidents directly to the DON.

In March or April of 1980 J.B., nursing assistant, reported the following incident to the DON: Between 5:00 and 5:30 AM, J.B. walked into the downstairs room of resident #58 and saw D.G. on his hands and knees getting off the right side of the resident's bed at its foot. J.B. saw D.G.'s trousers on the floor near a pile of crumpled chux. She saw him pull his trousers up. The bed rail was down on the right side of the bed. The privacy curtain was pulled partially around the bed on the left side by the window and across the foot of the bed.

J.B. reported the incident to the DON when she came on duty. The DON advised J.B. not to tell anyone else of the incident. There was no evidence of reprimand or retraining.

In October of 1980 J.T., nursing assistant, reported to the DON that she observed D.G. standing at the side of the bed of resident #58 with his pants unzipped exposing his genitals. The female resident was sitting on the bed within reaching distance. There was no evidence of any follow-up investigation by the DON, no evidence of report to the Administrator and no evidence of reprimand or retraining.

In the spring of 1981, six months later, J.T., nursing assistant, reported that she saw D.G. sitting on the side of the bed of resident #58. His pants were open, exposing his genitals. The female resident was nude and he was holding her around the waist, on his lap, her back towards him. The incident was reported to the DON who directed J.T., charge aide, to observe D.G. more closely. The DON told J.T. "she (DON) would take care of it". There

was no evidence of follow-up investigation, reprimand or retraining. There was no evidence of a report to the Administrator.

J.B., nursing assistant, reported that sometime after the spring of 1980 she walked in unexpectedly on D.G. in the employee lounge, adjacent to the kitchen. D.G. was sitting with his pants down and fondling his genitals. D.G. jumped up, apologized and said he was scratching an itch. J.B. reported the incident to the DON. D.G. later reported to J.B. that the DON spoke to him about the incident. D.G. said that the DON told him to go into the bathroom.

On August 22, 1982 L.Z., nursing assistant, heard female resident #142 say "Hey! Hey!" Upon entering the room to answer the call, L.Z. saw D.G. fondling the bare breasts of the resident. There was no washcloth in the hands of D.G. The incident was reported to K.V.B., the charge R.N. who contacted the Administrator. The Administrator obtained signed witness statements from L.Z. and J.T. D.G. was interviewed by the Administrator and the DON and was told not to report to work. The Administrator spoke with D.G.'s parents about the incidents. D.G. was terminated from employment at Ridgeview Nursing Home on August 25, 1982.

The two female residents involved were both elderly, senile, confused with medical and/or chronic mental illnesses. They required assistance with all personal and medical needs. They were physically incapable of self defense. Most of the incidents took place in the basement level rooms where D.G., nursing assistant, was assigned to work unsupervised, except for an occasional check by other nursing assistants.

The failure to remove the employee from direct resident care constituted substantial probability that serious mental or physical harm would result to the residents involved in these incidents and other residents entrusted to his care.

Continued

2. The following restrictions shall be imposed on admission and retention of residents to the rooms in the lower level of the facility:

   - Only residents who are capable of independent mobility.

   - Only residents who are mentally capable of defending themselves or employing assistance as needed in event of emergency or potential personal harm.

NOV # 253250

The nursing home social worker designee has been appointed to receive resident abuse complaints and any complaints alleging violations of residents rights. The social worker designee has been instructed to immediately report any serious incident verbally to the Administrator with a written report to follow within two weeks. This will be kept on file. The report will include all actions taken by staff and the Nursing Home Administrator.

The nursing home will only admit residents to room # 17 who are capable of independent mobility and are mentally capable of defending themselves or employing assistance in the event of emergency or potential personal harm.

The male employee D.G. was discharged from his position on 8/25/82 when the Nursing Home Administrator was informed of this incident.

This matter has been appealed.

Ronald T. Dewitt — Signature of Licensee or Designee

N.H.A. — Title

5-19-83 — Date